Proper medical charting is critical to protecting against legal risk

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If you represent medical providers for long enough, you have likely heard the timeless adage posited by the plaintiff's bar "if you didn't chart it, it didn't happen." While this phrase is commonly used in medical training to push providers to strive for better documentation and should be at the forefront of any discussion regarding patient care and safety, it also highlights issues that can arise from documentation shortcomings in the legal arena.

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The One Witness that "Never Lies or Dies"

A patient's medical record is a living, breathing legal document that sometimes serves as the best evidence—if not the only evidence—to determine whether the applicable standard of care was met by a medical provider.

For attorneys who represent healthcare providers, sometimes the patient's medical records can be the one piece of evidence that saves the day, but other times they can be the straw that breaks the camel's back. In countless medical malpractice cases, provider negligence can often be proven by poor, incomplete, or completely absent documentation. In contrast, negligence can be disproven simply by proper and effective charting.

As Benjamin Franklin so shrewdly expressed, "An ounce of prevention is worth a pound of cure," and nowhere is that more applicable than in the context of preventing medical and legal issues with proper and effective patient documentation. The efforts made by the provider at the time he or she is documenting a patient's file can go a long way in preventing medical errors, adverse patient outcomes and—ultimately—medical liability.

The Pros and Cons of Electronic Documentation

In our modern world, most major health care systems have transitioned from handwritten paper charting to a completely electronic-based system. Electronic medical records are now a ubiquitous part of the overall landscape of healthcare in this country, making patient records more accessible than ever.

Yet while electronic medical records and health information systems have made compiling and sharing medical information easier and more efficient, it has also created its own set of problems.

Far too often, patient medical records are still incomplete or full of ineffective documentation. A few examples of this include copying-and-pasting of previous provider notes, overreliance on templates, late/untimely entries, falsification or alteration of records, incomplete documentation of care, or failure to document altogether.

Each of these deficiencies shares a common thread—the inability to facilitate communication between healthcare providers, which impedes diagnosis and treatment from an accurate and complete clinical picture of a patient.

All of these charting missteps put both the medical provider and healthcare system at risk of legal liability.

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An Incomplete Record May Be Your Next Lawsuit

Today's electronic medical records and corresponding information systems provide a greater wealth of patient data than what was typically included or available in the past. And while helpful, the increase in information creates more opportunity for errors, omissions, or mistakes that can ultimately lead to an unintended patient outcome and subsequent evidence against a provider in a legal proceeding.

In the context of a medical negligence case, documentation shortcomings can be used to, at the very least further a harmful narrative against a provider, or worse, confirm an allegation that the provider's care was substandard.

Providers must remember the audience for the medical records is vast and encompasses not only other medical providers, but also professional standard review organizations, insurers, quality assurance personnel, local and statewide health departments, the patient, and the plaintiff's attorney.

Best Practices to Minimize Your Risk

The fact-paced nature of modern patient care, which can lead to higher rates of poor medical documentation, is here to stay. Fortunately, common sense best practices are still the ultimate remedy. These include:

- Ensure documentation is accurate, complete, relevant, and timely.
- Avoid practices that lead to mixed messaging, including reliance on cut-and-paste functions.
- Read back information once it has been entered into the system.
- Provide a more thorough review of information prior to finalizing a chart entry.
- Participate in frequent continuing educational programs focused on improving patient record keeping.
- And most importantly — slow down and avoid rushing documentation.

Ultimately, every medical provider should ask whether his or her charting can properly, completely, and effectively communicate to all others who may review the information and rely upon it for patient care. This is true from the chief of neurosurgery all the way to the patient tech charged with documenting a patient's vital signs.

Ensuring that effective and proper documentation is the standard will have a resounding positive impact on patient care and will keep providers where we need them—with their patients and not in the courtroom.

About the Author

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